U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 02 May 2007

In the Matter of:

H. B.,
Claimant,

Case No. 2006 BLA 00024

v.

PEABODY COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest.

Before: STUART A. LEVIN
Administrative Law Judge

DECISION AND ORDER

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.* In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

A formal hearing was scheduled in this matter for November 14, 2006, however, at the request of both parties, it was determined that the matter would be decided on the record. All parties were afforded a full opportunity to present evidence and argument as provided in the Act and the regulations issued thereunder, found at Title 20, Code of Federal Regulations. The record consists of Director's Exhibits Numbers 1 through 89 (hereinafter referenced as "DX").

ISSUES

The following issues were listed on Form CM-1025:

1. Whether the Claim was timely filed;
2. Whether the person upon whose disability the claim is based is a miner;
3. The length of coal mine employment;
4. Whether the Claimant has pneumoconiosis as defined in the Act and regulations;
5. Whether the Claimant=s pneumoconiosis arose out of coal mine employment;

6. Whether the Claimant is totally disabled;
7. Whether the Claimant=s disability is due to pneumoconiosis;
8. Whether the Claimant has one dependent for the purposes of augmentation; and
9. Whether the named Employer is the Responsible Operator;
(DX 87).

Findings of Fact and Conclusions of Law

Procedural Background

The Claimant filed his first application for benefits on August 6, 1970. (DX 30). It was deemed abandoned and administratively closed on July 7, 1980. (DX 30). He filed his second application for benefits on May 19, 1998. (DX 1). A Decision and Order Granting Benefits was issued by Administrative Law Judge Pamela Lakes Wood on February 6, 2001. (DX 43). In her decision, Judge Woods accepted the parties' stipulation of thirty-one years of coal mine employment and concluded that the Claimant had established the existence of complicated pneumoconiosis by means of the x-ray and CT scan evidence. Benefits were found to be payable as of August 1998, the date of the first x-ray reading of complicated pneumoconiosis.

Employer filed a timely appeal, and by Decision and Order dated April 17, 2002, the Benefits Review Board (the Board) remanded this matter for further consideration. (DX 60). The Board affirmed the finding of thirty-one years of coal mine employment and that employer was properly designated the responsible operator herein. The Board also upheld the weighing of the x-ray evidence by Judge Woods and her finding that the x-ray readings established the existence of complicated pneumoconiosis. It remanded the case, however, for further review of the CT scan evidence, directing that an equivalency determination needed to be made in order to determine whether the readings equated to a finding of complicated pneumoconiosis. Then all the relevant evidence needed to be reviewed in order to determine whether the existence of complicated pneumoconiosis had been established.

On July 24, 2002, Judge Woods issued a Decision and Order on Remand Granting Benefits. (DX 65). In her decision, Judge Woods made an equivalency determination and concluded that the CT scan evidence supported a finding of complicated pneumoconiosis. She again awarded benefits. Employer filed a timely appeal and on August 21, 2003, the Board issued a Decision and Order remanding this matter for further consideration consistent with its opinion (DX 66, 72). In this decision, the Board vacated the finding made by Judge Woods in her first decision, with regard to the x-ray evidence, which finding The Board had previously affirmed. In so doing, the Board found that Judge Woods erred in failing to analyze the x-ray interpretations of record from a quantitative and a qualitative standpoint, Judge Woods having instead calculated the number of physicians submitting positive and negative reports. Accordingly, The Board vacated the findings from the 2001 decision under Section 718.304(a) along with the equivalency finding with regard to the CT scan evidence; and, in addition, the Board ruled that the report of Dr. Fino needed to be considered, inasmuch as he also rendered an opinion as to the existence of complicated pneumoconiosis.

On December 2, 2003, Judge Woods issued an Order of Remand to obtain an additional x-ray reading to be arranged by the Director, and to allow the parties to submit additional

evidence pertinent to the issues raised by the Board on its most recent remand. (DX 74). After the submission of additional evidence a Proposed Decision and Order Awarding Benefits was issued on October 3, 2005 by the District Director. (DX 85). By letter dated October 5, 2005, the District Director advised Employer that the evidence submitted following the Remand Order issued by Judge Woods had been considered and based upon that evidence, it was determined that the Miner's entitlement date was June 1, 1992. (DX 85). Employer filed a timely request for a hearing and this matter was referred to the Office of Administrative Law Judges on December 21, 2005. (DX 87). By agreement of the parties, it was determined that this matter would be decided on the record. Because this claim was filed after the enactment of the Part 718 regulations, entitlement to benefits will be evaluated under the Part 718 standards. 20 C.F.R. § 718.2. In order to establish entitlement to benefits under Part 718, Claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) he suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) he is totally disabled, and (4) his total disability is caused by pneumoconiosis. *See generally Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994); *see also 20 C.F.R. §§ 718.201 – 718.204.*

Medical Evidence

Chest X-rays

Ex. No.	Date of X-ray	Physician/Qualifications	Impression
DX 32	8/6/71	Khan BCR	Mild generalized fibrosis and moderate emphysema
DX 30	5/30/73	Harrison BCR	Negative
DX 32	12/6/74	Nakatsuka BCR	Minimal scattered nodular fibrosis in both lung fields
DX 30	7/27/79	Sargent B BCR	q 1/1
DX 30	7/29/79	Reubenstein BCR	p 0/1
DX 84	6/5/92	Wiot B BCR	p/q 2/1 A
DX 32	6/5/92	Scott B BCR	q/q 1/1
DX 32	6/5/92	Wheeler B BCR	s/q 0/1
DX 84	12/18/96	Wiot B BCR	p/q 2/2 B
DX 32	12/18/96	Scott B BCR	s/t 1/1 A
DX 32			s/q 0/1

	12/18/96	Wheeler B BCR	
DX 84	4/28/98	Wiot B BCR	p/q 2/2 B
DX 32	4/28/98	Scott B BCR	q/t 1/1 A
DX 32	4/28/98	Wheeler B BCR	s/q 0/1
DX 14	8/21/98	McFarland B BCR	q/p 2/2 A
DX 15	8/21/98	Patel B BCR	q/q ½ B
DX 32	8/21/98	Scott B BCR	q/t 1/1 B
DX 32	8/21/98	Wheeler B BCR	s/q 0/1
DX 84	8/21/98	Wiot B BCR	p/q 2/2 B
DX 32	10/3/98	Scott B BCR	q/t 1/1 B
DX 32	10/3/98	Wheeler B BCR	No pneumo
DX 33	10/3/98	Pathak B BCR	q/t 2/2 B
DX 33	10/3/98	Aycoth B	q/r 2/3 B
DX 33	10/3/98	Ahmed B BCR	q/r 3/2 A
DX 84	10/3/98	Wiot B BCR	p/q 2/1 B
DX 33	10/22/98	Ahmed B BCR	q/r 3/2 A
DX 33	10/22/98	Aycoth B	q/r 2/3 B
DX 33	10/22/98	Pathak B BCR	q/t 2/2 B
DX 32	10/22/98	Scott B BCR	q/t 1/1 B
DX 32	10/22/98	Wheeler B BCT	s/q 0/1
DX 84	10/22/98	Wiot B BCR	p/q 2/1 B
DX 32	11/18/98	Scott B BCR	q/t 1/1 B
DX 32	11/18/98	Wheeler B BCR	s/q 0/1

DX 32	11/18/98	Zaldivar B	q/p 1/1 B
DX 33	11/18/98	Pathak B BCR	q/t 2/2 B
DX 33	11/18/98	Aycoth B	q/r 2/3 B
DX 33	11/18/98	Ahmed B BCR	q/r 3/2 A
DX 84	11/18/98	Wiot B BCR	p/q 2/1 B
DX 84	3/17/04	Wiot B BCR	p/q 1/2 B
DX 83	3/17/04	Barrett B BCR	Quality 2
DX 79	3/17/04	Binns B BCR	p/q 1/0 A
DX 79	3/17/04	Patel B BCR	t/q 1/1 B

In his reading of the June 5, 1992, December 18, 1996, April 28, 1998, August 21, 1998, October 3, 1998, October 22, 1998 and November 18, 1998 x-rays, Dr. Scott remarked that the changes found were probably due to tuberculosis (TB). (DX 32). In his readings of those x-rays, Dr. Wheeler listed a 3x5 cm scar and stated that pneumoconiosis was unlikely since the scarring was asymmetrical and involved apices.

In his report dated August 26, 2005, wherein Dr. Wiot stated that he had reviewed a large series of chest x-rays, he noted that the Claimant showed findings compatible with complicated pneumoconiosis on all studies submitted. His specific findings are set forth in the table above. (DX 84).

CT SCANS

A CT scan was taken on January 11, 1999 at the Charleston Area Medical Center. (DX 33). Dr. John Mega found it to be compatible with coal worker's pneumoconiosis and associated progressive massive fibrosis.

On January 20, 1999, Dr. George L. Zaldivar reviewed the CT scan and found it showed the presence of simple nodular pneumoconiosis. (DX 33). In his opinion, there were masses with the background of simple pneumoconiosis which represented complicated pneumoconiosis. He stated that while it was true that one could not be absolutely certain that one of these masses might not represent a cancer or residuals of old infection, given their location, and the fact that they were accompanied by smaller nodular lesions, the most likely diagnosis was simple and complicated pneumoconiosis. Dr. Zaldivar is a B-reader and he is board-certified in internal medicine and pulmonary disease.

On May 26, 2000, Dr. K. Pathak reviewed the CT scan and found changes compatible with complicated pneumoconiosis with chronic obstructive pulmonary disease. (DX 33). Dr. Edward Aycoth reviewed the CT scan on May 24, 2000. (DX 33). He found it to be positive for progressive massive fibrosis, finding 3 cm and 2 cm left upper lung irregular density effects and scattered rounded density opacities measuring up to 5 mm in diameter throughout both lungs. Dr. Ahmed reviewed the CT scan on May 24, 2000, finding it to have changes consistent with complicated pneumoconiosis. Drs. Pathak, Aycoth and Ahmed are board certified in radiology and B-readers.

Dr. William Scott reviewed the CT scan dated January 11, 1999. (DX 32). He found a 3 cm x 5 cm mass in the right upper lung and a 2 cm irregular mass in the left upper lung. He thought the changes seen were most likely due to tuberculosis of unknown activity, because the lack of a background of small, rounded opacities made it highly unlikely that the changes represented silicosis/CWP.

In his review of the January 11, 1999 CT scan, Dr. Paul Wheeler stated that he found a 3-4 cm focally calcified mass in the right upper lung surrounded by mainly linear fibrosis extending to lateral pleura, apex and medially to hilum. (DX 32). He also found a 1-2 cm mass in the lateral portion of the left upper lung. Pneumoconiosis was very unlikely, in his opinion, because the scarring was "asymmetrical and mainly linear/mass in RUL is focally calcified." He also found apical scarring and calcified granulomata in the lungs, hila and one in the liver. He noted that there were several granulomatous diseases which could give this pattern but TB was by far the most common.

Medical Reports

On July 29, 1979, Dr. Martin Fritzhand examined the Claimant and found him to be suffering from COPD and pneumoconiosis. (DX 30). In a medical report dated August 21, 1998, Dr. Rasmussen, relying upon the positive reading rendered by Dr. Patel, stated that the Claimant suffered from complicated pneumoconiosis, Category B. (DX 11). He also noted that the Claimant had no significant loss of lung function.

By report dated December 18, 1998, Dr. George Zaldivar stated that he examined the Claimant on November 18, 1998 as well as having reviewed the medical records submitted to him by counsel for Employer. (DX 33). Dr. Zaldivar found no pulmonary impairment. He did, however, find complicated pneumoconiosis to be present. In his comments regarding the chest x-ray, Dr. Zaldivar noted that most of what appeared to be simple pneumoconiosis resembled histoplasmosis rather than coal worker's pneumoconiosis. However, he also found an elongated mass in the right upper lobe which was compatible with complicated pneumoconiosis and "therefore some or all of these round nodules may be due to pneumoconiosis." Dr. Zaldivar recommended a high resolution CT scan to determine whether the lesions were in fact pneumoconiotic lesions or due to previous infection with heavy calcification in them. Dr. Zaldivar is board-certified in internal medicine and pulmonary disease.

In a report dated October 3, 1999, Dr. Gregory Fino reviewed the evidence of record. (DX 32). He noted that a finding of complicated pneumoconiosis had been made by some

physicians and remarked that it would be unusual to have Category B complicated coal worker's pneumoconiosis with normal lung function. He indicated an interest in reviewing the x-rays and CT scans. Dr. Fino is board-certified in internal medicine and pulmonary disease.

The deposition testimony of Dr. Paul Wheeler was taken on August 15, 2000. (DX 32). Dr. Wheeler is board-certified in radiology and he is a B-reader. Dr. Wheeler testified that he had the opportunity to review x-rays and one CT scan dated January 11, 1999. He also read seven x-rays spanning from 1992 to 1998. Dr. Wheeler testified that Claimant had an ill-defined infiltrate or fibrosis on the lateral portion of the right upper lobe more than the left lobe in the June 5, 1992 film. The film was compatible with TB of unknown activity. The subsequent x-rays he reviewed also revealed TB in his opinion.

Dr. Rasmussen examined the Claimant again on March 17, 2004. (DX 79). He noted the x-ray reading to have been t/q 1/1, B and diagnosed complicated pneumoconiosis as well as chronic bronchitis. He found no significant loss of lung function. Dr. Rasmussen is board-certified in internal medicine and forensic medicine. He is also a B-reader.

By report dated April 28, 2004 and in response to specific questions, Dr. D. Gaziano emphatically stated that the absence of respiratory disability does not indicate that a nonsmoking miner does not have complicated pneumoconiosis. (DX 80). Dr. Gaziano explained that complicated pneumoconiosis as described in this case as Category B, 3 x 5 cm (right) 2 cm (left), represented a small portion of the total lung being involved (less than 5%), and in a nonsmoker, the complicated pneumoconiosis may not be associated with measurable impairment. Dr. Gaziano stated that the rationale given that this did not present pneumoconiosis was in error. He explained that a lung cancer would not have been present in both lungs for six years without other signs. He also found that the discussion of possible TB not well founded for several reasons: (1) calcified granulomas are essentially ubiquitous in the general population and can be incorporated into a complicated pneumoconiosis; (2) the claimant never had clinical tuberculosis, and 93) Claimant's occupational history, clinical records, and x-rays established the presence of complicated pneumoconiosis. Dr. Gaziano is board-certified in internal medicine, pulmonary disease and chest disease.

DISCUSSION

By letter dated December 18, 2006, counsel for Employer stated that it was withdrawing its controversion of the issues of entitlement, however it was reserving its right to challenge any of the issues of entitlement in the future. Employer stated that, for purposes of the current adjudication, it recognized that the medical evidence indicated that the Claimant might have complicated pneumoconiosis but no totally disabling respiratory or pulmonary impairment. Agreeing that an award of benefits was proper, Employer indicated its intent to raise the issue of the onset of benefits, its position being that the earliest date on which benefits should be awarded was December of 1996. Employer pointed out that Claimant worked until July 26, 1993. Employer contends that while there was one positive reading of the June 5, 1992 x-ray, two readings of that same film were negative for complicated pneumoconiosis. According to Employer, the earliest film for which the majority of readings were positive was the December 18, 1996 x-ray and therefore, this is the earliest date that the preponderance of the evidence

shows complicated pneumoconiosis. Accordingly, December 18, 1996 is the date which should establish the onset date.

In a follow-up letter dated December 28, 2006, counsel for Employer stated that Employer was withdrawing its controversion of the issues of entitlement and withdrawing its request for a hearing. Counsel then went on to state that Employer was not, however, agreeing or stipulating to any issues of entitlement in this matter. Counsel explained that Employer recognized that a withdrawal of a request for a hearing on those issues raised a question about the onset date and requested that the onset date be set accordingly.

Thus, from the correspondence received in December of 2006, it appears that Employer no longer disputes the presence of complicated pneumoconiosis, and as discussed in detail below, the evidence supports Employer's decision. Employer does contest the Director's finding with regard to the date of entitlement, however. Employer believes benefits should commence as of December 1, 1996. As noted, the Director has indicated his position that benefits should be payable as of June 1, 1992. Claimant has not commented on this issue.

Section 411(c)(3)(A) of the Act, implemented by Section 718.304(a) of the regulations, provides that there is an irrebuttable presumption of total disability due to pneumoconiosis if the miner suffers from a chronic dust disease of the lung which, (A) when diagnosed by chest x-ray, yields one or more large opacities (greater than one centimeter in diameter) classified as Category A, B, or C; (B) when diagnosed by biopsy or autopsy, yields massive lesions in the lung; or (C) when diagnosed by other means, is a condition which would yield results equivalent to (A) or (B). 30 U.S.C. §921(c)(3)(A); 20 C.F.R. §718.304(a). The introduction of legally sufficient evidence of complicated pneumoconiosis does not automatically qualify a claimant for the irrebuttable presumption found at 20 C.F.R. §718.304. In determining whether claimant has established invocation of the irrebuttable presumption of total disability due to pneumoconiosis pursuant to Section 718.304, the administrative law judge must weigh together all of the evidence relevant to the presence or absence of complicated pneumoconiosis. *Lester v. Director, OWCP*, 993 F.2d 1143, 1145-46, 17 BLR 2-114, 2-117-18 (4th Cir. 1993); *Melnick v. Consolidation Coal Co*., 16 BLR 1-31, 1-33-34 (1991)(*en banc*). Additionally, the Fourth Circuit court has held that "[b]ecause prong (A) sets out an entirely objective scientific standard" for diagnosing complicated pneumoconiosis, that is, an x-ray opacity greater than one centimeter in diameter, the administrative law judge must determine whether a condition which is diagnosed by biopsy or autopsy under prong (B) or by other means under prong (C) would show as a greater-than-one-centimeter opacity if it were seen on a chest x-ray. *Eastern Associated Coal Corp. v. Director, OWCP [Scarbro]*, 220 F.3d 250, 255, 22 BLR 2-93, 2-100 (4th Cir. 2000); *Double B Mining, Inc. v. Blankenship*, 177 F.3d 240, 243, 22 BLR 2-554, 2-561 (4th Cir. 1999). Reviewing the x-ray evidence, it is apparent that that evidence is in conflict. Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers= radiological qualifications, *Dixon v. North Camp Coal Co.,* 8 BLR 1-344 (1985), when assigning evidentiary weight to x-ray interpretations based on the readers qualifications. *Goss v. Eastern Associated Coal Co.*, 7 BLR 1-400 (1984). Accordingly, greater weight may be assigned to an x-ray interpretation of a B-reader, *Aimone v. Morrison Knudson Co.,* 8 BLR 1-32 (1985). Similarly, the numerical superiority of the x-ray interpretations may be weighed, *Edmiston v. F & R Coal Co.*, 14 BLR 1-65 (1990), but cautiously, since Fourth Circuit, under whose jurisdiction this case

arises, has addressed the issue of numerical superiority in weighing x-ray evidence. In *Adkins v. Director,* OWCP, 958 F.2d 49 (4th Cir. 1992), the court exhibited disfavor in "counting heads" and in *Copley v. Arch of West Virginia, Inc.*, Case No. 93-1940 (4th Cir. June 21, 1994)(unpubl.), the Court held that the conflicting interpretations of one x-ray should be evaluated to determine whether the individual x-ray is negative or positive. The Court went on to conclude that "[c]onflicts between x-rays should then be weighed in context to determine whether there is pneumoconiosis." Guided by these authorities, we consider the evidence adduced in this record. None of the x-rays prior to 1992 were read as positive for complicated pneumoconiosis. Dr. Wiot read the June 5, 1992 x-ray as positive for complicated pneumoconiosis. Drs. Wheeler and Scott found that x-ray to be negative for complicated pneumoconiosis. In reviewing these three readings, Dr. Wiot had the opportunity to review the entire span of x-rays from 1992 to 2004. Drs. Scott and Wheeler had the opportunity to review x-rays from 1996 through 1998. As Dr. Wheeler noted in his deposition testimony, the radiologist who has the opportunity to review a series of x-rays spanning a period of time, all at one time, is provided an advantage. Dr. Wiot had the advantage described by Dr. Wheeler, being the only physician to sit down and review x-rays spanning a period from 1992 to 2004 at one time; however, in compliance with Atkins v. Westmoreland Coal Co., BRB No. 05-0170 BLA (10/13/2005), (Judge McGranery, dissenting), that advantage may not be considered despite Dr. Wheeler's testimony.[1] When reviewing the readings of this x-ray, taking into consideration the qualifications of the physicians and their affiliations, and the fact that Dr. Wheeler never detected complicated pneumoconiosis on any of Claimant's x-rays, while Dr. Scott denied that the category A opacity he detected was not complicated pneumoconiosis, notwithstanding the preponderance of the record evidence demonstrating the existence of complicated pneumoconiosis. I, therefore find the reading rendered by Dr. Wiot to be worthy of the greatest weight. Thus, I find the June 5, 1992 x-ray to be positive for complicated pneumoconiosis.

In reviewing the x-ray taken on December 18, 1996, I would note that Employer, based upon the onset date it seeks, seems to agree that this x-ray is positive for complicated pneumoconiosis, which is consistent with the findings rendered by Dr. Wiot. Dr. Scott's contrary opinion is diminished since he insisted, contrary to a preponderance of the evidence, that Claimant does not, in fact, have complicated pneumoconiosis. Similarly, Dr. Wheeler never found a large opacity or complicated pneumoconiosis. For the reasons set forth above, I have accorded the report of Dr. Wiot greater weight with respect to this x-ray than the contrary opinions by Drs. Scott and Wheeler.

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[1] In Atkins, the Board twice rejected a judge's decision to accord credence to the testimony of a radiologist who had indicated, as Dr. Wheeler did here, that it is medically advantageous if a physician can compare a series of x-rays at one sitting. In Atkins, it was Dr. Wiot who testified that it is preferable to read a series of x-rays simultaneously. The trier of fact in Atkins had explained that he accepted the medical opinion of the radiologist, and, therefore, he credited a doctor who had an opportunity to read, at one sitting, a May 3, 1999 x-ray simultaneously with those taken on January 22, 1996, and December 3, 1997, because the evidence showed that it enhanced the physician's ability to detect the presence of complicated pneumoconiosis over that of the other Board-certified radiologists and B-readers who read several x-rays but at different times. This rationale, which was provided by an expert radiologist in the Atkins record, much like Dr. Wheeler's testimony here, was rejected by the Board as: "… inadequate to explain the weight accorded to the conflicting readings by radiological experts." Atkins is published at http://www.dol.gov/brb/decisions/blklung/unpublished/Oct05/05-0170.htm).

Indeed, the opinions of Dr. Wheeler and Dr. Scott are contradicted by every other dually qualified radiologist, B-readers, in the record. Thus, Drs. Wheeler and Scott found the April 28, 1998 x-ray to be negative while Dr. Wiot found it to be positive for complicated pneumoconiosis. The August 21, 1998 x-ray was read as positive by Drs. McFarland, Patel, and Wiot, Dr. Scott also finding simple pneumoconiosis and a large opacity, while Dr. Wheeler found the x-ray to be negative for simple and complicated pneumoconiosis.

The October 3, 1998 and October 22, 1998 x-rays were found to be positive by Drs. Scott, Pathak, Aycoth, Ahmed and Wiot, while Dr. Wheeler found complicated pneumoconiosis to be absent and Dr. Scott opined that the opacity he found was unrelated to complicated pneumoconiosis. The November 18, 1998 x-ray was found to have large opacities by Drs. Zaldivar, Scott, Pathak, Aycoth, Ahmed and Wiot. Dr. Wheeler found none. Finally, the March 17, 2004 x-ray was found to have large opacities by Drs. Binns, Patel and Wiot.

For the reasons set forth above, I find the readings by Drs. Wheeler and Scott to be outweighed by the positive readings of record. I find that Claimant has established, by a preponderance of the x-ray evidence that he is suffering from complicated pneumoconiosis. Since there is no autopsy or biopsy evidence, left to be considered is the diagnosis of complicated pneumoconiosis by "other means." In this case, there are several readings of the January 11, 1999 CT scan to be considered. Dr. Zaldivar, a pulmonary specialist, found that it established complicated pneumoconiosis. Dr. Pathak reviewed the CT scan and also found changes compatible with complicated pneumoconiosis. Drs. Scott and Wheeler found the CT scan to be indicative of changes which were most likely due to tuberculosis. Additionally, the record contains medical reports, Dr. Rasmussen finding complicated pneumoconiosis, relying on the positive x-ray reading rendered by Dr. Patel. Dr. Fritzhand also found complicated pneumoconiosis, relying on a positive x-ray reading by Dr. Patel. Their opinions do not assist in a determination under Section 718.304(c).

Dr. Gregory Fino, in a report dated October 3, 1999, also reviewed the evidence of record. He noted that a finding of complicated pneumoconiosis had been made by some physicians and he remarked that it would be unusual to have Category B complicated coal worker's pneumoconiosis with normal lung function. He indicated an interest in reviewing the x-rays and CT scans. Dr. Fino is board-certified in internal medicine and pulmonary disease.

Dr. Gaziano reviewed the evidence and specifically equated the finding of the mass found in the Claimant's lung, of 3 x 5 cm (right) 2 cm (left), as a Category B complicated pneumoconiosis. I find his opinion sufficient to establish an equivalency determination and find it establishes the existence of the disease. This finding is supported by the CT scan interpretations of Drs. Pathak and Zaldivar. By report dated April 28, 2004 and in response to specific questions, Dr. Gaziano emphatically stated that the absence of respiratory disability does not indicate that a nonsmoking miner does not have complicated pneumoconiosis. In response to Dr. Fino's theory, he explained that complicated pneumoconiosis as described in this case as Category B, 3 x 5 cm (right) 2 cm (left), represented a small portion of the total lung being involved (less than 5%), and in a nonsmoker, the complicated pneumoconiosis may not be associated with measurable impairment. Dr. Gaziano stated that the absence of impairment was a flawed rationale for concluding that Complicated pneumoconiosis was not present. Further, he

explained that a lung cancer would not have been present in both lungs for six years without other signs. He also found that the discussion of possible TB not well founded for several reasons: (1) calcified granulomas are essentially ubiquitous in the general population and can be incorporated into a complicated pneumoconiosis; (2) the claimant never had clinical tuberculosis, and (3) Claimant's occupational history, clinical records, and x-rays established the presence of complicated pneumoconiosis. Dr. Gaziano's credentials are, at least, equal to Dr. Fino's, and as a pulmonary specialist, his credentials are superior to Drs. Wheeler and Scott in the non-radiographic diagnosis of respiratory and pulmonary disease, and I find his report better reasoned than the opinions expressed by Drs. Fino, Wheeler, and Scott, better supported by the clinical data, including the CT scan data, and better corroborated by the quantitative weight of the medical evidence establishing complicated pneumoconiosis. I have, therefore, accorded Dr. Gaziano's opinion greater weight than contrary opinions of Drs. Fino, Wheeler, and Scott. Based upon the totality of the "other evidence" I find that complicated pneumoconiosis has also been established pursuant to 20 C.F.R. §718.304(c). Even assuming, *arguendo*, that it had not been, I find, when weighing all evidence together, that the evidence is sufficient to establish that the Claimant suffers from complicated pneumoconiosis. In this respect, I find the x-ray evidence of complicated pneumoconiosis sufficient to establish the existence of the disease, even when weighed with all evidence under §718.304.

Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. If a claimant establishes that he has complicated pneumoconiosis, the onset date is the month during which complicated pneumoconiosis was first diagnosed. *Truitt v. North American Coal Corp.*, 2 BLR 1-199, 1-203 to 1-204 (1979). In *Truitt*, the Board held this to be the case notwithstanding the fact that the study was interpreted as positive two years after it was taken. In *Williams v. Director, OWCP*, 13 BLR 1-28 (1989), the Board held that if the evidence does not reflect when the claimant's simple coal worker's pneumoconiosis became complicated, the onset date for payment of benefits shall be the month during which the claim was filed, unless the evidence affirmatively establishes that the claimant had only simple pneumoconiosis for any period subsequent to the date of filing.

The instant claim was filed in 1998. The first diagnosis of complicated pneumoconiosis was in the interpretation of the 1992 x-ray by Dr. Wiot, albeit several years after the x-ray was taken. Employer argues that the onset date is December 1, 1996, apparently in recognition of the December 18, 1996 x-ray which was positive for complicated pneumoconiosis; however, the first indication of complicated pneumoconiosis appeared on the June 5, 1992 x-ray as later diagnosed by Dr. Wiot, whose interpretation of this x-ray, as discussed above, was accorded the greatest weight. As mandated by the Board's decision in Truitt, the onset date is, therefore: "…the month during which complicated pneumoconiosis was first diagnosed." Pursuant to Truitt, benefits are payable as of June 1, 1992.

Finally, Employer has raised the issue of the lack of a disabling respiratory impairment. Although Dr. Gaziano explained medically why that the presence of complicated pneumoconiosis is not inconsistent with the absence of a disabling respiratory impairment, a miner who has complicated pneumoconiosis may invoke the irrebuttable presumption set forth at

20 C.F.R. §718.304, and whether or not he suffers from a respiratory impairment is irrelevant. Similarly, whether or not he was working during the period of entitlement is also irrelevant. *See 20 C.F.R. §§718.304; 725.504.*

For all of the foregoing reasons, I find, based upon the medical opinion of Dr. Wiot, that the June, 1992 x-ray is the first evidence that the Claimant suffers from complicated pneumoconiosis. Accordingly, benefits are payable as of June 1, 1992. Therefore;

ORDER

IT IS ORDERED that Employer pay to Claimant all benefits to which he is entitled under the Act commencing as of June 1, 1992.

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Stuart A. Levin
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the District Director's office. See 20 C.F. R. Sections 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. Section 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., N.W., Room N-2117, Washington, DC 20210. See 20 C.F.R. Section 725.481.

If an appeal is not timely filed with the Board, the decision becomes the final order of the Secretary of Labor pursuant to 20 C.F. R. Section 725.479(a).